South Carolina Department of Disabilities and Special Needs

Report on Administrative Review for Improper Conduct toward Consumer

(Provide brief summarized information in this report—explicit details should be provided according to the Outline of Report)

The Administrative Review for Improper Conduct Toward Consumer is conducted by non-ICF/MR providers upon notification from the state investigative agency that an abuse investigation will not be conducted.

Reviewer:	Name:	Position:	Date/Time Appointed:
Provider:			
Victim 1:	Birthdate:	Victim 3:	Birthdate:
Victim 2:	Birthdate:	Victim 4 :	Birthdate:
Alleged Perpetrator(s)	Name & Title (Indicate which victim #):		
Witnesses:			
Residence of Consumer(s):	☐ Family/guardian home or own home ☐ CRCF ☐ CTH I ☐ CTH II ☐ SLP I ☐ SLP II ☐ Other (Specify): Descriptive Location of Residence (i.e., family home, own home, Jim Doe CTH I):		

INCIDENT:

Date of Incident:		Time of Incident: ☐ AM ☐ PM	
☐ Date of Incident Unknown	*If Date of Incident is unknown, indicate Date Incident Reported (shown on Initial Report):*		
Type Location of Incident:	☐ Family/guardian home or own home ☐ CRCF ☐ CTH I ☐ CTH II ☐ SLP I ☐ SLP II ☐ Day Service ☐ Other (Specify):		
Descriptive Location of Incident: (i.e., family home, own home, Jim Doe CTH I)			
Type of Suspected Abuse:	☐ Exploitation ☐ Neglect ☐ Physical ☐ Psychological ☐ Sexual		
Description of incident (brief summary):			
Nature and extent of injury/harm & medical treatment received:			

ISSUES/RISK SITUATIONS IDENTIFIED:

☐ Personnel Actions	Comment:
☐ Staff Training	Comment:
☐ Environmental Modifications	Comment:
☐ Policy/Procedure Violations	Comment:
☐ Local Services Contract	Comment:
☐ Awareness Training for People Served	Comment:

Recommendations Pertaining to These Issues/Situations:

REVIEW OUTCOME:

☐ Rules, Regulation or Policy Violation(s)
(Specify which rule, regulation or policy was violated):

☐ Management Action Taken (Specify what action was taken):

☐ Other (Specify):

Comments:

ACTION TAKEN/TO BE TAKEN:

Personnel Action Taken:
☐ Administrative Leave W/Out Pay ☐ In-Service Training ☐ Legal Charges ☐ NA/No Staff Involved
☐ None ☐ Reinstatement ☐ Resignation/No Longer Works for Agency
☐ Transferred ☐ Unknown ☐ Verbal Reprimand ☐ Written Reprimand

Comments:

Abuse Prevention/Corrective Action to Avoid Reoccurrence:
(Include each action, completion date, staff responsible for implementation of each action and staff title)

Other Action Taken:

OUTSIDE INVESTIGATIVE AGENCIES:

Has an investigation by an outside agency been completed? ☐ Yes ☐ No
Or, is case still under investigation by an outside agency? ☐ Yes ☐ No

Agency	*Date of Referral*	*Contact Person*	*Intake # or Case ID #*	*Result of Agency's Investigation If Known at Time of Completion of Administrative Review*
☐ DSS				
☐ Local Law Enforcement				
☐ Ombudsman				
☐ SLED				
☐ Attorney General				
☐ Other (Specify):				

FINDINGS BASED ON ADMINISTRATIVE REVIEW:

(Please provide only brief summarized information pertaining to the conclusion of the review)

Disposition of Abuse Allegation: (at time of review)
☐ Substantiated/Founded (Perpetrator Known
☐ Substantiated/Founded (Perpetrator Unknown)
☐ Unsubstantiated/Unfounded
☐ Other Agency Investigating

OUTLINE OF REPORT (*Attach detailed information according to this outline which pertains to the alleged abuse*):

A. *Chronology of Events*

This section shall include in paragraph form, the re-creation of the events prior to, during, and following the incident of alleged abuse. It shall contain, to the extent possible, the names of the individuals, their action, and the time frame during which the alleged abuse occurred.

B. *Discussion*

This section will list all facts of the case.

C. *Conclusion*

D. *Supporting Documents to be Included*

1. Signed and dated statements from each person involved
2. Unusual Occurrence Form
3. Photographs
4. OD Report
5. Injury Report
6. Other documents, if needed during the Administrative Review, such as:
   a. Body check report
   b. Doctor/Nurse reports
   c. Work schedule
   d. Security report

SIGNATURE

Executive Director/ CEO/ Facility Administrator (or Designee)	Date	Name of Person Completing Form

Send completed forms within ten (10) working days (excluding state and federal holidays) of discovery of suspected abuse, neglect or exploitation to: Director of Quality Management, SCDDSN, PO Box 4706, Columbia, SC 29240, FAX # 803.898.7450.